Ensure that coders and physicians understand the intricacies of medical necessity

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Medical necessity is a topic that permeates Medicare rules and other regulations governing delivery of healthcare services to Medicare beneficiaries.

During the three-year recovery audit contractor (RAC) demonstration project, RACs identified $823.8 million in improper payments made to inpatient hospitals. Approximately 36% of the improper payments were due to incorrect coding, and 41% were due to services rendered in a medically unnecessary setting—often referred to by RACs as "wrong setting" improper payments.

RACs attributed 62% of overpayments to errors related to medically unnecessary services or settings. For more information, view Appendix F of the *Medicare Recovery Contractor Program: An Evaluation of the 3-Year Demonstration*, released in June 2008.

Understand the definition of medical necessity

Medical necessity is complex because there is debate regarding what constitutes "necessary" as it relates to healthcare services. Consider the following Medicare definition of medical necessity under Title XVIII of the Social Security Act, section 1862 (a)(1)(a):

Notwithstanding any other provisions of this tile, no payment may be made under Part A or Part B for any expenses incurred for items or services, which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Such terminology is foreign to physicians and has essentially no bearing on the day-to-day practices of clinical medicine.

In physicians' minds, medical decision-making inherently satisfies all medical necessity requirements for the services they provide and/or diagnostic tests they order.

Medicare carrier and fiscal intermediary Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) succinctly define medical necessity requirements. Covered diagnoses, documentation requirements, and limitations of coverage for specific services are also included in the many promulgated LCDs and NCDs that serve as a roadmap for a provider's establishment of medical necessity.

Despite these guidelines, challenges continue to surface regarding how to establish medical necessity. Ultimately, a physician's clinical judgment is the guiding principle behind the appropriateness of medical necessity when it comes to inpatient versus outpatient observation designation.

Choose wisely when admitting patients

RACs are not bound to apply commercially available screening criteria, such as Interqual, when determining whether an inpatient admission is appropriate. Providers that participated in the demonstration project learned quickly that RACs followed their own guidelines and definitions of medical necessity when they issued denials for inpatient admissions due to lack of medical necessity. Consider the following excerpt from a standard denial letter sent by Health Data Insights, the RAC that oversaw the demonstration project in Florida and South Carolina:

Screening criteria such as Interqual Level of Care and Millman Care Guidelines are intended merely as screening guidelines, are not dispositive on the issue of existence of medical necessity with respect to any particular claim, and do not eliminate the need to utilize independent clinical judgment when reviewing claims. Further, these criteria reflect clinical interpretation and analyses, and cannot alone provide the sole basis for definitive decisions.

Understand the physician's responsibility in designating patient status

When a physician decides whether to admit a patient to the hospital or to observation for further clinical work-up and management, he or she must incorporate a host of factors into his or her clinical judgment and medical decision-making. As stated in the *Medicare Benefit Policy Manual,* Chapter 1:

The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's bylaws and admission policies, and the relative appropriateness of treatment in each setting. Factors to consider when making the decision to admit include:

- *The severity of the signs and symptoms exhibited by the patient*
- *The medical predictability of something adverse happening to the patient*
- *The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted*
- *The availability of diagnostic procedures at the time when and at the location where the patient presents*

During the demonstration project, RACs characterized a large percentage of identified improper payments as medically unnecessary services that occurred in the wrong setting. However, one question still remains: How many of these identified claims were, in reality, necessary services provided in clinically appropriate settings? For how many claims did physicians simply not document their clinical judgment and complex medical decision-making?

Medical record documentation must easily convey the clinical acuity, risk of morbidity and mortality, and level of unpredictability that necessitated an inpatient admission instead of outpatient observation.

Understand this case and point

During the demonstration project, RACs denied a large number of admissions for one- and two-day inpatient stays that had a final diagnosis of chest pain due to lack of medical necessity.

Consider the following clinical documentation that often appears on ER claims to support and substantiate medical necessity for inpatient admission:

Acute chest pain, rule out myocardial infarction. Cardiac enzymes are negative so far in the emergency department. Plan is to order serial cardiac enzymes and electrocardiograms, monitor labs.

Note that the documentation does not include the physician's risk assessment of the patient's chest pain. The documentation also does not include a discussion of the potential unpredictability of the patient's clinical course, a concern for an unfavorable outcome, and the clinical significance of cardiac enzymes relative to the physician's decision to admit the patient as an inpatient.

It's no surprise that this type of documentation results in costly denials.

Understand the coder's role

What is the coder's role in the complicated maze of establishing of medical necessity?

First, the coder must be cognizant of the concept of medical necessity as it relates to principal diagnosis assignment. When considering the principal diagnosis, coders must first determine whether the documentation for the selected diagnosis meets the clinical definition.

Does the principal diagnosis explain the clinical reason for admission that best establishes medical necessity, thereby reducing the incidence of potential RAC-initiated medical necessity denials? The concept of medical necessity becomes even more important when a physician admits a patient for two separate clinical reasons when he or she believes that each is equally dominant during the admission as well as after additional examination.

Coders must not fall into the trap of determining what condition meets medical necessity. Instead, they should focus on the following rationale: "If A, then not B." In other words, when a patient does not present with clinical condition A, then he or she should not be admitted on the basis of clinical condition B."

Sometimes, coders don't grasp the concept that patients may present to the ER with two clinical conditions, yet only one condition meets the definition of medical necessity and thus the clinical definition of the principal diagnosis.

Step up to the plate

Over the last five years, coding has transitioned from a task to a role that requires coders to possess a heightened level of core competencies and skill sets when reviewing and interpreting medical record documentation and assigning ICD-9 codes.

Accurately reporting patients' health status and clinical acuity to third-party entities is the basis for outcome studies, quality-of-care reporting, risk adjustment in pay-for-performance initiatives, and financial adjustment under a recently proposed hospital inpatient MS-DRG Medicare Value-Based Purchasing program slated to begin October 2012.

This Value-Based Purchasing Program, in conjunction with Medicare's proposal to eventually combine current hospital and physician inpatient payment methodologies into one system, will further intertwine the relationship between coding and medical necessity.

Coders should act now to understand and recognize the importance of clinical documentation beyond ICD-9 code assignment, particularly in light of the advent of the permanent RAC program.

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